

Division of Medicaid	New:	Date:
State of Mississippi	Revised: X	Date: 03/01/07
Provider Policy Manual	Current:	04/01/09
Section: <u>Community-Based Mental Health Services</u>	Section: 21.01	
<u>Therapeutic and Evaluative Mental Health</u>	Pages: 1	
<u>Services for Children</u>	Cross Reference:	
Subject: Introduction		

Medicaid, as authorized by Title XIX of the Social Security Act, is a federal and state program of medical assistance to qualified individuals. Each state designates a single state agency for the administration of Medicaid. State law has designated the Division of Medicaid (DOM), Office of the Governor, as the single state agency to administer the Medicaid program in Mississippi.

The mental health services described in this manual are provided through the Expanded Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. ~~for children under 21 years of age.~~ EPSDT, a mandatory service under Medicaid, provides preventive and comprehensive health services for Medicaid-eligible children and youth up to age twenty-one (21). The service ends on the last day of the 21st birthday month. Adults age twenty-one (21) and older are not eligible for EPSDT services. Mental health services include therapeutic (bio-psycho-assessment, individual, family, and group therapy, day treatment) and evaluative (psychological, developmental, and neuropsychological evaluation) services. All services must be medically necessary. Services that require prior authorization must be authorized by the Division of Medicaid prior to service delivery.

A provider requesting certification as a Medicaid-authorized provider must complete and submit a provider enrollment packet. Enrollment forms must be signed and returned to the fiscal agent along with all requested documentation. When the enrollment packet is received it will be reviewed for completeness and, if complete, submitted to the Executive Director of DOM for approval or disapproval. If approved, the enrollment forms will be sent to the fiscal agent so that a Medicaid provider number may be assigned. If the Executive Director disapproves, the applicant will be notified in writing and the reasons for the disapproval will be clearly stated.

A mental health service provider's participation in the Mississippi Medicaid program is entirely voluntary. However, if a provider does choose to participate in Medicaid, the provider must accept the Medicaid payment as payment in full for those services covered by Medicaid. The provider cannot charge the beneficiary the difference between their usual and customary charge and Medicaid's payment. The provider cannot accept payment from the beneficiary, bill Medicaid, and then refund Medicaid's payment to the beneficiary (except in cases of retroactive eligibility). Services not covered under the Medicaid program may be billed directly to the Medicaid beneficiary.

The Mississippi Medicaid program purchases needed health care services for beneficiaries as determined under the provision of the Mississippi Medical Assistance Act. DOM is responsible for formulating program policy. DOM staff is directly responsible for the administration of the program. Under the direction of DOM, the fiscal agent is responsible for processing claims, issuing payments to providers, and for notifications regarding billing. Medicaid policy as it relates to these factors is initiated by DOM.

Division of Medicaid	New:	Date:
State of Mississippi	Revised: X	Date: 03/01/07
Provider Policy Manual	Current:	04/01/09
Section: Community-Based Mental Health Services	Section: 21.02	
Therapeutic and Evaluative Mental Health	Pages: 2	
Services for Children	Cross Reference:	
Subject: Provider Categories	21.06 Therapeutic Services 21.06	
	21.16 Prior Authorization 21.16	
	22.0 Mental Health/ Psychiatry	
	Nurse Practitioners 27.04	

Any provider of Community-Based Mental Health Services Therapeutic and Evaluative Mental Health Services for Children must be an approved Medicaid provider and qualified as indicated to provide the services listed:

Nurse Practitioner: An individual with a minimum of a Master's degree who is licensed under state law to practice, under the supervision of a physician, as a nurse practitioner. ~~under state law.~~

Nurse Practitioners are authorized under EPSDT to provide **limited** developmental evaluations (developmental screenings) if they possess the necessary training, experience and expertise to be able to provide such evaluations within the scope of their license. Refer to Provider Policy Manual Section 27.04 for Nurse Practitioners policy.

- ~~Services, which may be provided by a licensed Psychiatric Mental Health Nurse Practitioner (PMHNP), are covered in Section 22, Mental Health/Psychiatry.~~

Physician: An individual (**medical doctor or doctor of osteopathy**) licensed under State law to practice medicine.

Developmental Pediatrician: A physician who has specialized training in developmental pediatrics. Developmental pediatricians may provide developmental evaluations.

Psychiatrist: A physician who is board certified in psychiatry or who has successfully completed an approved residency in psychiatry. Psychiatrists who wish to provide day treatment must follow the guidelines for day treatment and obtain prior authorization from DOM. Refer to Provider Policy Manual Section 21.06 for Therapeutic Services policy and Section 21.16 for Prior Authorization policy.

- ~~Refer to Section 21.06, Therapeutic Services for guidelines related to day treatment and Section 21.16, Prior Authorization in this manual. Mental health services, which may be provided by a psychiatrist, are covered in Section 22, Mental Health/Psychiatry.~~

Psychologist: An individual licensed under state law to practice psychology independently. Psychologists are authorized to provide any of the following services:

- Psychological evaluations, when prior authorization is requested/received from DOM.
- Bio-psycho-social assessments.
- Individual, family and group therapy.

-
-
- ~~• Day treatment, when provided as outlined in Section 21.06 and prior authorization is requested/received from DOM for each beneficiary who participates.~~
 - Day treatment when prior authorized for and provided in accordance with policy. Refer to Provider Policy Manual Section 21.06 for Therapeutic Services policy.

Psychologists with appropriate training, experience, and expertise in neuropsychology or developmental psychology may provide assessments in those areas.

Social Worker: An individual licensed under state law as a licensed certified social worker (LCSW). Social workers are authorized to provide any of the following services:

- Bio-psycho-social assessments.
- Individual, family and group therapy.
- ~~• Day treatment, when provided as outlined in Section 21.06 and prior authorization is requested/received from DOM for each beneficiary who participates.~~
- Day treatment when prior authorized for and provided in accordance with policy. Refer to Provider Policy Manual Section 21.06 for Therapeutic Services policy.

Mental Health Group: One or more approved Medicaid providers listed in this section who have been through the provider enrollment process as a group.

Division of Medicaid	New:	Date:
State of Mississippi	Revised: X	Date: 03/01/07
Provider Policy Manual	Current:	04/01/09
Section: Community-Based Mental Health Services	Section: 21.03	
Therapeutic and Evaluative Mental Health	Pages: 2	
Services for Children	Cross Reference:	
Subject: Definitions		

Background & Information Gathering: The first portion of the psychological evaluation. During this meeting, the psychologist meets with the child's family and the child to determine the medical necessity of testing and gather relevant background information.

Billing Provider: The entity (individual or group) who bills and receives payment for services delivered to Medicaid beneficiaries.

Collateral: A person with whom contact is necessary to ensure that the best interests of the child are served, but whose relationship with the child is of a secondary, rather than a primary, nature. Examples of collaterals include, but are not limited to, teachers, youth court counselors, and health care professionals. Collateral contacts are allowed only as a part of case management services and during the background and information gathering portion of the evaluation process. Collateral contacts are eligible for reimbursement by Medicaid only when they are done face-to-face.

CFR: Code of Federal Regulations.

DSM: Diagnostic and Statistical Manual.

Family: Members of the child's family and others (guardian or other caregivers, such as the Mississippi Department of Human Services staff and foster family members) with whom the child has a family-like relationship.

Feedback Session: The third and final section of the psychological evaluation, during which the psychologist meets face to face with the referral source (if possible), the child's family, and when appropriate, the child to review evaluation results and recommendations.

Medical Necessity: The standard of appropriateness which any mental health service must meet in order to be eligible for reimbursement through Medicaid. In order to be "medically necessary," mental health services must be (1) consistent with the diagnosis or treatment of the child's condition or illness; (2) in accordance with the standards of good medical practice; (3) required for reasons other than the convenience of the child, the child's family member(s), or the provider; and (4) the most appropriate level of mental health services which can be safely and efficiently provided to the child in a community-based setting.

Medical Necessity: The Division of Medicaid (DOM) may provide coverage for covered mental health services when it is determined that the medically necessary criteria and guidelines listed below are met. "Medically necessary" or "medical necessity" shall mean health care services that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- Appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the patient's medical condition; and

- Compatible with the standards of acceptable medical practice in the United States; and
- Provided in a safe, appropriate and cost-effective community-based setting given the nature of the diagnosis and the severity of the symptoms; and
- Not provided solely for the convenience of the beneficiary or family, or the convenience of any health care provider; and
- Not primarily custodial care; and
- There is no other effective and more conservative or substantially less costly treatment service and setting available; and
- The service is not experimental, investigational or cosmetic in nature.

All Mississippi Medicaid program policies, exclusions, limitations, and service limits, etc. apply. The fact that a service is medically necessary does not, in itself, qualify the service for reimbursement.

Prior Authorization (PA): Refers to the verification of medical necessity for a particular procedure or service which must be obtained from DOM prior to the delivery of that procedure/service in order for it to be eligible for reimbursement by DOM. It is the Medicaid provider's responsibility to secure prior authorization from DOM before delivering any service which requires PA. (Section 21.16, Prior Authorization). Refer to Provider Policy Manual Section 21.16 for Prior Authorization policy.

PRTF: Psychiatric Residential Treatment Facility.

Referral Question: The reason for which a psychological evaluation is being requested. The psychologist is responsible for determining the appropriateness of testing to address the referral question. In those instances in which a referral question can be addressed through other means, the psychologist should review these issues with the referral source and assist in determining an appropriate course of action.

SED (Serious Emotional Disturbance): A descriptive category which identifies any person from birth up to age 24 twenty-one (21) who meets one of the eligible DSM diagnostic categories and whose identified disorder has resulted in functional impairment in basic living skills, instrumental living skills, or social skills.

Servicing Provider: The mental health professional who provides mental health services to a Medicaid beneficiary.

Division of Medicaid	New:	Date:
State of Mississippi	Revised: X	Date: 03/01/07
Provider Policy Manual	Current:	04/01/09
Section: Community Based Mental Health Services	Section: 21.04	
Therapeutic and Evaluative Mental Health	Pages: 1	
Services for Children	Cross Reference:	
Subject: General Requirements		

In order to be eligible for Medicaid reimbursement, all services discussed in this policy section must meet the following general requirements:

- Services must be provided in a community-based setting.
- All Services must be personally and directly provided by the person who is identified as the "servicing provider".
- Services must be based on beneficiary need and not the convenience of the beneficiary, the beneficiary's family, or the provider.
- A-provider Providers may bill only for the actual time spent in service delivery.

Only DOM can provide any interpretations, clarifications, or exceptions to the Medicaid rules, regulations, or policy and will do so only in writing.

Division of Medicaid	New:	Date:
State of Mississippi	Revised: X	Date: 03/01/07
Provider Policy Manual	Current:	04/01/09
Section: Community-Based Mental Health Services	Section: 21.05	
<u>Therapeutic and Evaluative Mental Health</u>	Pages: 1	
<u>Services for Children</u>	Cross Reference:	
Subject: Exclusions		

Therapeutic and Evaluative Mental Health Services not covered/reimbursed by the Division of Medicaid include, but are not limited to, the following:

- In accordance with federal regulations, telephone contacts are not eligible for Medicaid reimbursement.
- Educational interventions of an academic nature (e.g., tutoring sessions) are not eligible for Medicaid reimbursement.
- In accordance with federal regulations, failed and/or canceled appointments are not eligible for Medicaid reimbursement, regardless of the circumstances, and cannot be billed to the Medicaid beneficiary (HCFA Transmittal Notice MCD-43-94).
- Medicaid will not reimburse more than once for the same service provided to any beneficiary on any given date, regardless of the setting(s) in which the service was provided. Federal matching funds are not available for services that are considered to be duplications of service. It is Mississippi Medicaid policy that if the federal match is not available, it is not covered in the Medicaid program.

For example, if a child is seen in a community mental health center for individual therapy and is seen for individual therapy later that same day by an LCSW in independent practice, only one of these services will may be eligible for reimbursement by Medicaid. It is the provider's responsibility to coordinate services for the child/adolescent beneficiary with the parent/family member.

- Community-based mental health services described in this manual are not eligible for reimbursement when a beneficiary is in a Medicaid-covered inpatient facility (e.g., medical hospital, freestanding acute psychiatric facility, psychiatric residential treatment facility, or nursing facility). Providers of Medicaid-covered inpatient services are reimbursed on a per diem basis, and that fee is considered to be an all-inclusive rate for room and board and any ancillary services the patient may need, including therapeutic and evaluative services as defined in this section. The inpatient provider may recommend that a patient should receive therapeutic and evaluative services during the inpatient stay, but if an outside provider provides the service, the inpatient provider is responsible for reimbursing that provider.
- Paperwork, unless completed during the session and relevant to the treatment goals, is not eligible for Medicaid reimbursement. Time spent completing a plan of care form or a prior authorization request online via web portal will not be reimbursed by DOM. ~~is not eligible for Medicaid reimbursement.~~

**Section: Community-Based Mental Health Services
Therapeutic and Evaluative Mental Health
Services for Children**

**Section: 21.06
Pages: 3
Cross Reference: Prior
Authorization 21.16**

Subject: Therapeutic Services

Psychotherapy Services

Psychotherapy Services are defined as intentional, face-to-face interactions (conversations or non-verbal encounters, such as play therapy) between a mental health therapist and a client (an individual, family or group) in which a therapeutic relationship is established to help resolve symptoms of the child's mental and/or emotional disturbance. Psychotherapy services include bio-psycho-social assessment, individual therapy, family therapy, and group therapy.

- A **Bio-psycho-social assessment** is the securing, from the child and/or his/her family, of the child's presenting problem(s), problem history, family background, medical history, current medication(s), educational/vocational achievement, history of previous mental health treatment, source of referral or other pertinent information in order to determine the nature of the individual's or family's problem(s), the factors contributing to the problem(s), and the most appropriate course of treatment for the child.

Even though assessment is an ongoing process that is inseparable from treatment, there are points (primarily intake or initiation of treatment) when a comprehensive "review of systems" in the child's life is appropriate. It is this comprehensive assessment that is referred to as "bio-psycho-social assessment".

A bio-psycho-social assessment is eligible for reimbursement by Medicaid at the beginning of a treatment relationship between a child and a mental health provider or when renewing treatment after a lapse of six (6) months or longer.

- **Individual therapy** is defined as one-on-one psychotherapy that takes place between a mental health therapist and a child.
- **Interactive individual therapy** is defined as one-on-one psychotherapy using non-verbal communication and/or physical aids that takes place between a mental health therapist and a child. It should be provided to children who have not yet developed or have lost their expressive communication skills to explain symptoms and their response to treatment or do not have the cognitive ability to understand the mental health therapist if ordinary adult language is used.
- **Family therapy** is defined as psychotherapy that takes place between a mental health therapist and a child's family members, with or without the presence of the child. Family therapy may also include others (Mississippi Department of Human Services staff, foster family members, etc.) with whom the child lives or has a family-like relationship.
- **Group therapy** is defined as psychotherapy that takes place between a mental health therapist and no more than eight (8) children at the same time. It is expected that most psychotherapy groups will consist of at least four (4) children. However, since particular circumstances (e.g., absences) could prohibit a group of that size, the minimum number of children allowed for group psychotherapy is two (2). Possibilities include, but are not limited to, groups that focus on anger management and/or conflict resolution, survival of sexual abuse, adjusting to divorce in the family, coping with ADHD Attention Deficit/Hyperactivity Disorder (ADHD), social skills training,

self-esteem enhancement, etc

- **Interactive group therapy** is defined as psychotherapy using non-verbal communication and/or physical aids that takes place between a mental health therapist and no more than six (6) children at the same time. It is expected that most interactive psychotherapy groups will consist of at least four (4) children. However, since circumstances could prohibit a group of that size, the minimum number of children allowed for interactive group therapy is two (2).

Psychotherapy services are eligible for Medicaid reimbursement when at least one of the following conditions applies:

- The child is experiencing significant psychosocial or environmental stressors and would benefit from added support.
- The child is at risk for more restrictive interventions and/or placements if intervention is not provided.
- Strengthening the child's coping and/or social skills would likely help prevent deterioration of the child's mental status in the future.
- There is an identified treatment need that is recognized by the child.

Psychotherapy services are **NOT** eligible for reimbursement by Medicaid when any of the following conditions apply:

- The child is unable to benefit from therapy due to cognitive impairment, developmental delays or any other reason.
- The child has ~~communicated verbally or behaviorally that s/he is not interested verbally or behaviorally~~ communicated disinterest in participating in therapy and has not responded to attempts to adapt therapy to **meet** his/her needs.
- Family therapy sessions are billed for multiple siblings in a family on the same day. It is expected that one family therapy session per family per day is as much therapy as any family can benefit from. For example, if three siblings—all Medicaid beneficiaries—are seen together in a family session, that is **one** family session and is billed under **only one** beneficiary's Medicaid ID number.
- It is an educational intervention of an academic nature (e.g. tutoring).
- It is billed for time spent completing the plan of care forms.

Day Treatment

Day treatment is a behavioral intervention program, provided in the context of a therapeutic milieu, which provides children/adolescents with serious emotional disturbances (SED) the intensity of treatment necessary to enable them to live in the community. Day treatment is the most intensive outpatient program available to children and adolescents.

Day treatment is eligible for reimbursement by Medicaid when **ALL** of the following conditions exist:

-
-
- It is provided by an approved Medicaid provider through a program that has been certified by the Mississippi Department of Mental Health (DMH).
 - It is provided in accordance with the minimum standards for day treatment set by DMH.
 - It is approved for provision to a beneficiary through the prior authorization process. (~~Section 21.16, Prior Authorization~~ Refer to Provider Policy Manual Section 21.16 for Prior Authorization policy. ~~AND~~
 - It is provided as an alternative to acute psychiatric hospitalization or residential treatment or as a transition between acute or residential treatment and less intensive outpatient treatment.

Day treatment is **NOT** eligible for reimbursement by Medicaid when any of the following conditions exist:

- Prior authorization has not been received from DOM.
- It is provided on the same day as group therapy.
- It is provided for alcohol and/or substance abuse.

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Date: Date: 03/01/07 04/01/09
Section: Community Based Mental Health Services Therapeutic and Evaluative Mental Health Services for Children	Section: 21.07 Pages: 5 Cross Reference: 18.03 MH/ Psychiatric Residential Treatment Facility PRTF/Admission 18.03 21.01 Introduction Provider Categories 21.02 21.16 Prior Authorization 21.16	
Subject: Evaluative Services		

Evaluative Services are those services, which provide mental health assessments of beneficiaries. All evaluations require prior authorization by DOM in order to be eligible for reimbursement. ~~Refer to Section 21.16, Prior Authorization of this manual.~~ Refer to Provider Policy Manual Section 21.16 for Prior Authorization policy.

Evaluative Services are composed of three parts:

- **Background and Information Gathering**, during which information is gathered to best address the referral question and determine the course of testing,
- **Evaluation**, during which the testing is completed, and
- **Feedback**, during which test results and recommendations are reviewed with the referral source (if possible), the child's family, and when appropriate, the child.

Psychological Evaluation

A **psychological evaluation** is the assessment of a beneficiary's cognitive, emotional, behavioral, and social functioning by a licensed psychologist using standardized tests, interviews, and behavioral observations.

A psychological evaluation may be eligible for Medicaid reimbursement when one or more of the following conditions exist:

- There is a history of unexplained treatment failures.
- There are questions regarding diagnosis and/or treatment that a psychological evaluation might help to answer.
- Such Evaluation is required by DOM for admission to a psychiatric residential treatment facility (PRTF).
- ~~When a child is initially placed into custody of the Mississippi Department of Human Services. In order to be eligible for reimbursement, the evaluation must be completed within 90 days of the custody order.~~

Examples of reasons a psychological evaluation may be eligible for reimbursement include, but are not limited to the following:

- The need to confirm or rule out the existence of a major diagnosis, such as depression, psychosis, or Attention Deficit Hyperactivity Disorder (ADHD) when behavioral observation and history supports the suspected diagnosis.
- The existence of a pattern of inability to learn, but not to the extent that the child qualifies for evaluation for Special Education services.
- The need to assess a child's potential for success in a certain type of program.

A psychological evaluation is **NOT** eligible for reimbursement through Medicaid when any of the following conditions apply:

- It is provided as a routine procedure or requirement of any program or provider, including pre-commitment hearings.
- It is to determine educational needs/problems when such assessment is the responsibility of the school system in which the child is enrolled.
- It is within one (1) year of a previous psychological evaluation, unless necessary for admission to a Medicaid-certified PRTF or if needed to assess progress in a child with an evolving condition (i.e., head injury, severe depression). Refer to Section 18.03, Mental Health/ Psychiatric Residential Treatment Facility in this manual Refer to Provider Policy Manual Section 18.03 for PRTF Admission policy.

In order for a psychological evaluation to be eligible for Medicaid reimbursement, the psychologist completing the psychological evaluation must ensure that all of the following occur:

- Psychological testing is indicated by the referral question. If it is not, it is the responsibility of the psychologist to educate the referral source as to those circumstances in which testing is or is not indicated.
- An initial session is held with the child and child's family before any testing is initiated. The purpose of this session is to determine the medical necessity of psychological evaluation and to gather background information. Collateral contact may be included in the background and information gathering session, and the time spent with those collateral contacts is eligible for Medicaid reimbursement only when that contact is face-to-face. If it becomes apparent during the session that the child and/or family would benefit from certain strategies/interventions (e.g., bibliotherapy, behavioral approaches for children with attention difficulties), these interventions should be implemented and their effectiveness evaluated before the necessity of testing is reconsidered. **Though part of the evaluation process, the background and information gathering session should be billed as either a bio-psycho-social assessment or family therapy (with or without the beneficiary, as appropriate).**
- If/when testing is indicated, the testing process and the written report must document the medical necessity, adequately address the referral question, and reflect an understanding of the background strengths, values and unique characteristics of the child and family.
- The psychologist has appropriate training, experience and expertise to administer, score and interpret those instruments used.
- The instruments used are psychometrically valid and appropriate to the referral question, the child's age and any special conditions presented by the child and/or the testing situation. In those instances in which more than one instrument could be used (e.g., IQ testing), the psychologist

chooses the most psychometrically sound one unless otherwise indicated by the unique characteristics of the test-taker (e.g., the child is non-English speaking, physically unable to manipulate materials).

- A written report is generated within thirty (30) calendar days of completion of the assessment. However, if the child's treatment needs indicate an earlier report deadline, the report is generated as soon as possible. The report synthesizes the information gathered through interviews, observation, and standardized testing, including a discussion of any cautions related to testing conditions or limitations of the instruments used.
- The written report provides practical recommendations for those working with the child. These recommendations should reflect recognition of the child and family's strengths as well as their areas of need.
- If computer-generated scoring or interpretation reports are used as one source of data, they must be integrated into the report as whole. Reports that include computer generated feedback without this integration are considered unacceptable.
- Unless doing so would present a hardship to the child and family, the child's family and, when appropriate, the child are provided with face-to-face (when possible) verbal feedback regarding test results, interpretation and recommendations within fourteen (14) calendar days of the written report. The referral source is included if requested at the time of the referral. The child's family and the child shall be given adequate opportunity to ask questions and give their input regarding the evaluation feedback. If face-to-face feedback is not possible, feedback is provided through alternative means. **However, part of the evaluation process, the feedback session should be billed as family therapy, with or without the beneficiary present, as appropriate.**
- Concrete plans are made for follow-up based on evaluation recommendations and feedback from the referral source, the family and, when appropriate, the child (e.g., therapy appointment is made, the family is given information about mentoring programs), and these plans are documented in writing.
- Information obtained from collateral contacts is included in the report.

Developmental Evaluation

A **developmental evaluation** is the assessment of the current cognitive, social and motor functioning of children younger than three years of age or children with such severe mental or physical disabilities that standardized intellectual assessment is not possible. A developmental evaluation may be:

- Limited (e.g., Developmental Screening Test II, Early Language Milestone Screen), or
- Extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments, e.g., Bayley Scales of Infant Development).

A developmental evaluation is eligible for reimbursement by Medicaid when all of the following conditions apply:

- It is conducted by a physician or a psychologist with knowledge/expertise in developmental evaluation.

-
- It would assist in treatment program planning for a child less than three (3) years of age or a child with a severe disability.
 - There exists the need to determine the existence of a major diagnosis; the child's inability to learn or to determine the child's potential success in a certain type program and the child has been unable to respond to traditional instruments.

Developmental evaluation is **NOT** eligible for reimbursement when any of the following conditions apply:

- The referral question may be adequately answered through behavioral observation and family interviews.
- Standardized intellectual assessment is indicated and the child is three (3) years or older with no severe disabilities.

In addition to the assurances for administering psychological evaluations listed in this section, the provider administering the developmental evaluation must ensure that the limitations of the psychometric properties and predictive validity of such instruments are considered when synthesizing information and giving written and verbal feedback regarding results.

Neuropsychological Evaluation

A **neuropsychological evaluation** is testing/assessment, which is intended to describe and diagnose the neurocognitive effects of medical disorders, which impinge directly or indirectly on the brain. A neuropsychological evaluation is an enhanced psychological evaluation, consisting of a psychological evaluation expanded to include special features to assess specific neurological functions. Therefore it may be billed **instead of** but **not simultaneous with** a psychological evaluation.

A neuropsychological evaluation is defined as comprehensive neuropsychological testing (e.g., Halstead-Reitan, Luria,) which consists primarily of individually administered ability tests that comprehensively sample domains that are known to be sensitive to the functional integrity of the brain (e.g., abstraction, memory and learning, attention, language, problem-solving, sensorimotor functions, constructional praxis, etc.). Neuropsychological testing does not rely on self-report questionnaires, rating scales or projective techniques, but rather employs procedures, which are objective and quantitative in nature and require the patient to demonstrate directly his/her level of competence in a particular cognitive domain.

Neuropsychological screening is considered to be a part of the neuropsychological evaluation and therefore cannot be provided as a discrete service.

A neuropsychological evaluation may be eligible for reimbursement by Medicaid when at least one of the following conditions apply:

- Other interventions have been attempted but failed.
- Previous psychological evaluation indicates neuropsychological deficits with supporting justification.
- There is evidence of brain involvement.
- The results are used in treatment planning and placement decisions.

Neuropsychological evaluations are **NOT** eligible for reimbursement by Medicaid when any of the following conditions apply:

- The only question is to rule out ADHD.
- Previous testing did not support the suspicion of organic involvement.

In addition to ~~these~~ responsibilities outlined in Provider Policy Manual Section 21.04 21.02 Provider Categories, the psychologist administering the neuropsychological evaluation must: ~~ensure that both of the following conditions apply:~~

- ~~S/he is~~ Be adequately trained to administer, score and interpret neuropsychological instruments.
- Integrate results of Feedback from medical reports and tests ~~are integrated~~ into the evaluation and recommendations.

Division of Medicaid	New:	Date:
State of Mississippi	Revised: X	Date: 03/01/07
Provider Policy Manual	Current:	04/01/09
Section: Community-Based Mental Health Services	Section: 21.08	
Therapeutic and Evaluative Mental Health	Pages: 2	
Services for Children	Cross Reference: Maintenance of	
	Records 7-03 7.03	
Subject: Clinical Record Documentation Requirements		

Clinical Record

The clinical record is an essential tool in treatment. It is the central repository of all pertinent information about the beneficiary. It provides an accurate chronological accounting of the treatment process - assessment, planning, intervention, evaluation, and revision. Clinical records must be complete, accurate, accessible, and organized.

Treatment Plan

A treatment plan must be developed and implemented for each beneficiary no later than the date of the third therapy session and must include, at a minimum:

- A multi-axial diagnosis.
- Identification of the child's and/or family's strengths.
- Identification of the clinical problems, or areas of need, that are to be the focus of treatment.
- Treatment goals for each identified problem.
- Treatment objectives that represent incremental progress towards goals, coupled with target dates for their achievement.
- Specific treatment modalities and/or strategies that will be employed to reach each objective.
- the Date of implementation and signatures of the provider and beneficiary.

Treatment plans must be kept in the case record and must be reviewed and revised as needed, or at least every three (3) months. Each review must be verified by the dated signatures of the provider and beneficiary. **The Physician, Nurse Practitioner, Psychologist, and Clinical Social Worker must sign the treatment plan for the services which he/she each will provide to the beneficiary.**

Services

A clinical note for each therapeutic service provided must be in the case record. The clinical note must include all of the following documentation:

- the Date of service
- Type of service provided
- Time session began and time session ended
- the Length of time spent delivering the service

- ~~who received or participated~~ Identification of individual(s) receiving or participating in the service
- ~~who provided the service~~
- a brief Summary of what transpired in the session ~~and~~
- ~~relate to the~~ Evidence that the session relates to the goals and objectives established in the treatment plan ~~and~~
- Name, title, and signature of servicing provider providing the service
- ~~be authenticated by the signature and title of the person who provided and documented the service.~~
- Name, title, and signature of the individual who documented the services

~~Evaluation reports must be dated and signed by the provider who conducted the evaluation.~~

Documentation of evaluations evaluative services must also include the dates and amount of time spent, including beginning and ending session times, in assessment/testing and the amount of time spent preparing a report. Evaluation reports must be dated and signed by the provider who conducted the evaluation.

~~Refer to Section 7.03, Maintenance of Records for additional documentation requirements. Refer to Provider Policy Manual Section 7.03 for additional Maintenance of Records policy.~~

~~All professional and institutional providers participating in the Medicaid program are required to maintain legible, accurate, and complete records that disclose and justify the services rendered and billed under the program and, upon request, make these records available to representatives of DOM in substantiation of any and all claims. These records must be maintained a minimum of five (5) years to comply with all state and federal regulations and laws. In order for DOM to fulfill its obligation to verify services rendered to Medicaid beneficiaries and those paid for by Medicaid, the provider must maintain auditable records that will substantiate the claim submitted to Medicaid. DOM, and/or the fiscal agent have the authority to request any patient records at any time to conduct a random sampling review and/or document any services billed by the provider. If the provider's records do not substantiate services paid for under the Mississippi Medicaid program, as previously noted, the provider will be asked to refund to DOM any money received from the Medicaid program for any such non-substantiated services. If a refund is not received within thirty (30) days, a sum equal to the amount paid for such services will be deducted from any future payments that are deemed to be due the provider. A provider who knowingly or willfully makes or causes to be made, a false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under federal and state criminal laws. A false attestation can result in civil monetary penalties, as well as fines, and may automatically disqualify the provider as a provider of Medicaid services.~~

~~Refer to Section 7.03, Maintenance of Records for additional documentation requirements.~~

Section: Community-Based Mental Health Services
Therapeutic and Evaluative Mental Health
Services for Children

Section: 21.09
Pages: 2
Cross Reference:

Subject: Consent to Bill Medicaid

Providers participating in the Mississippi Medicaid Program must obtain consent to bill Medicaid for services provided to Medicaid beneficiaries. It is the responsibility of the provider to obtain consent from the beneficiary or the parent/legal guardian of the minor child and maintain this documentation in the clinical record.

This authorization is valid until withdrawn by written notice from the beneficiary, parent/legal guardian or after one (1) year from the date of signature, whichever comes first.

Consent to Bill Medicaid

On behalf of my child, _____, Medicaid ID# _____, I consent to the provision of mental health services and request that payment of authorized Medicaid benefits for such services be made to _____.

I authorize the above-named provider to release to the Division of Medicaid or its fiscal agent any information about my child, which is needed to determine the benefits payable for those services.

This authorization is good until withdrawn in writing by me or after one year from the date of my signature, whichever comes first.

Signature: _____

Date: _____

Division of Medicaid	New: X	Date: 08/01/03
State of Mississippi	Revised: X	Date: 04/01/09
Provider Policy Manual	Current:	
Section: <u>Community-Based Mental Health Services</u> <u>Therapeutic and Evaluative Mental Health</u> <u>Services for Children</u>	Section: 21.10 – 21.14	
	Pages: 1	
	Cross Reference:	
Subject: Reserved for Future Use		

Sections 21.10 through 21.14 are RESERVED FOR FUTURE USE.

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Date: Date: 03/01/07 04/01/09
Section: Community-Based Mental Health Services Therapeutic and Evaluative Mental Health Services for Children	Section: 21.15 Pages: 2 Cross Reference: Maintenance of Records 7.03 21.06 Therapeutic Services 21.06 21.16 Prior Authorization 21.16	
Subject: Limitations to Service Provision		

There are several factors, which dictate the quantity of services, which may be provided within any given time frame.

Maximum Units

identifies Maximum Units is defined as ~~refers to~~ the maximum number of service units within any of the following categories of service that are eligible for Medicaid reimbursement on any given day.

- **Individual Therapy:** Only one (1) individual therapy service (regardless of the length of the session) per beneficiary per day is eligible for reimbursement.
- **Family Therapy:** Only one (1) family therapy service per beneficiary per day is eligible for reimbursement, whether the beneficiary is present for the service or not. If the beneficiary is present for any part of the session, it is considered "family therapy with the beneficiary present". Family therapy cannot be provided on the same day as a bio-psycho-social assessment.
- **Group Therapy:** Up to two (2) units of group psychotherapy per beneficiary per day may be eligible for reimbursement when:
 - Two distinct sessions, each having mutually exclusive goals and objectives, are provided, **AND**
 - Two sessions per day are medically necessary, **AND**
 - Two sessions per day are appropriate and in accordance with good practice standards, **AND**
 - Both sessions are provided by the same mental health professional, **AND**
 - Documentation in the clinical record substantiates that the above criteria were met.
- **Bio-psycho-social Assessment:** Only one (1) bio-psycho-social assessment service per beneficiary per day is eligible for reimbursement. This service cannot be provided on the same day as family therapy. ~~See section 21.06, Therapeutic Services, for further guidelines on the provision of this service. Refer to Provider Policy Manual Section 21.06 for Therapeutic Services policy.~~
- **Psychological Evaluation:** Psychological evaluation service units are calculated on an hourly basis. The maximum number of service units allowable per beneficiary per day is four (4) units. The yearly standard for a psychological evaluation is four (4) units. The current number of units per beneficiary, which are eligible for reimbursement on any given day, may be found on the website listed below.

- **Neuropsychological:** Neuropsychological evaluation service units are calculated on an hourly basis. The maximum number of service units allowable per beneficiary per day is ten (10) units. The yearly standard for neuropsychological evaluation is ten (10) units. The current number of units per beneficiary, which are eligible for reimbursement on any given day, may be found on the website listed below.
- **Developmental Evaluation:** DOM may reimburse for only one (1) developmental evaluation (whether limited or extended) per beneficiary per day. is eligible for reimbursement. Limited developmental evaluation services are calculated per service. The maximum number of services allowable per beneficiary per day is one (1) service. The yearly standard for a limited developmental evaluation is one (1) service. Extended developmental evaluation services are calculated per service. The maximum number of services allowable per beneficiary per day is one (1) service. The yearly standard for an extended developmental evaluation is two (2) services.
- **Day Treatment:** Day treatment service units are calculated on an hourly basis. The maximum number of service units allowable per beneficiary per day is five (5) units. The current number of units per beneficiary, which are eligible for reimbursement on any given day, may be found on the website listed below.

Detailed current information on the above services may be found on the DOM website at <http://www.medicaid.ms.gov/MentalHealthServices.aspx>. ~~www.dom.state.ms.us.~~

~~The website will provide a link to "Fee Schedules for Medicaid Provider Services". Once this link is accessed the provider should look for "Billing Guidelines for Community-Based Mental Health Services, Section 21".~~

Duplication of Service

Duplication of Service is defined as refers to the provision of the same service to the same beneficiary by the same or a different provider on the same day. For example, if a child is seen in a community mental health center for individual therapy and is seen for individual therapy later that same day by an LCSW or psychologist in independent practice, only one of these services will may be eligible for reimbursement by Medicaid. Likewise, individual therapy provided by a mental health therapist and individual therapy with medication management provided by a psychiatrist in the same clinic (or a different one) would be considered a duplication of services and only one of the two services would be eligible for reimbursement.

In all cases where duplicate service claims have been filed, the claim that is filed first is the one that will may be paid. If the beneficiary is receiving mental health services at more than one location from more than one provider, it is each provider's responsibility to coordinate those services with the beneficiary/family members ~~or his/her family members~~ in order to avoid service duplication.

Yearly Service Standards

Yearly Service Standards are defined as identify the maximum quantity of services per beneficiary under the age of 24 twenty-one (21) that are eligible for reimbursement within a fiscal year. Service standards, as well as procedure codes for each service, and other details which pertain to billing, is are all subject to change. Current billing guidelines can be found on the DOM website at www.dom.state.ms.us <http://www.medicaid.ms.gov>. The website will provide a link to "Fee Schedules for Medicaid Provider Services". Once this link is accessed the provider should look for "Billing Guidelines for Therapeutic and Evaluative Services for Children." ~~"Billing Guidelines for Community-Based Mental Health Services,~~

~~Section 21".~~ If additional services beyond those identified in the service standards are medically necessary within the same fiscal year, the provider may request additional service units from DOM through the prior authorization process. ~~outlined in Section 21.16.~~ Refer to Provider Policy Manual Section 21.16 for Prior Authorization policy.

Division of Medicaid	New:	Date:
State of Mississippi	Revised: X	Date: 03/01/07
Provider Policy Manual	Current:	04/01/09
Section: Community-Based Mental Health Services	Section: 21.16	
Therapeutic and Evaluative Mental Health	Pages: 3-4	
Services for Children	Cross Reference: Limitations to	
	Service Provision 21.15	
Subject: Prior Authorization		

Definition

Prior authorization (PA) refers to the verification of medical necessity for a particular procedure or service, which must be obtained from DOM prior to the delivery of that procedure/service in order for it to be eligible for reimbursement by DOM. It is the Medicaid provider's responsibility to secure prior authorization from DOM before delivering any service which requires PA.

Mental Health Services Requiring Prior Authorization PA

In the area of Mental Health Services, those services, which require PA, are as follows:

- All evaluations (psychological, developmental, neuropsychological) for all beneficiaries. The preparatory (background/information gathering) and follow-up (feedback) requirements for evaluations do NOT require PA.
- All psychotherapy (bio-psycho-social assessment, individual, family, and group therapy) services for children younger than three (3) years of age.
- Psychotherapy services for beneficiaries aged 3-20 that exceed the service standards. Refer to Section 21.15, Limitations to Service Provision. Refer to Provider Policy Manual Section 21.15 for Limitations to Service Provision policy.
- Day treatment for all beneficiaries.

Prior Authorization PA Process

Prior authorization (PA) refers to the verification of medical necessity for a particular procedure or service, which must be obtained from DOM prior to the delivery of that procedure/service in order for it to be eligible for reimbursement by DOM. It is the Medicaid provider's responsibility to secure prior authorization from DOM before delivering any service which requires PA. PA requirements in this section do not apply to providers of outpatient hospital mental health services.

A Medicaid provider may request prior authorization for services by submitting a paper Plan of Care (POC) form (MA-1148) or by submitting a Prior Authorization request online via Web Portal at <https://msmedicaid.acs-inc.com/msenvision/index.do>.

If services have been given PA by DOM but additional therapeutic services are needed within the same fiscal year OR evaluative services require more hours of assessment than were originally requested or a longer time frame in which to complete the evaluation, then the provider should request the extended services/time by submitting an Addendum to Plan of Care (APOC) paper form (MA-1148A) or by submitting a Prior Authorization Addendum online via Web Portal.

Both the POC and APOC paper forms are available through DOM's fiscal agent. Instructions for

completing these forms are provided below. Paper POC and APOC forms should be submitted to:

Division of Medicaid
Bureau of Mental Health Programs
Walter Sillers Building
550 High Street, Suite 1000
Jackson, MS 39201

~~the current address for the Division of Medicaid, which may be found on the DOM website at www.dom.state.ms.us, and directed to the attention of Mental Health Services.~~

~~Paper~~ POC/APOC forms will be reviewed and a determination made by DOM. A copy of the form, with the determination noted and a Medicaid-authorized signature affixed, will be returned to the provider. ~~If services are approved, the form number (upper right) becomes the PA number (EPxxxxxx) which the provider uses to bill DOM.~~

~~Evaluations that are approved~~ Approved evaluations, submitted by paper POC forms or a Prior Authorization request online via the web portal, will be given a ~~three-month~~ three (3) month authorization. The evaluation must be completed within the three (3) month time frame in order to be eligible for reimbursement by DOM, unless a time extension is justified/approved through submission of an APOC form.

A Prior Authorization request submitted online will be assigned a PA number once it is submitted. The PA will be reviewed and a determination made by DOM. Approved and denied PAs and PA Addendums will be sent to providers through a remittance advice via web portal. Providers can also inquire about submitted PAs and PA Addendums via web portal.

Only one provider may be authorized to provide a particular service at a time. If, when a PA request is received, it is determined that another PA for that service is already on file for another provider, the requester will be asked to provide documentation (in the form of a signed statement from the beneficiary's parent/guardian) verifying the desire to change from the old provider to the new provider.

~~If a beneficiary is expected to~~ If the provider anticipates that the beneficiary will need more than the approved therapeutic services than are available to him/her, the provider should request the PA of additional services at least two (2) weeks prior to the expected need.

It is the provider's responsibility to secure authorization, when required, from DOM before providing services. ~~any service which requires PA.~~ In case of an emergent situation, the provider should fax a copy of the request form to DOM at 601-359-1383 601-576-4163. Tentative approval for service delivery may be granted depending on the circumstances, but the final approval upon which reimbursement depends cannot be given until the original copy of the PA request is received.

Instructions for Completing the Plan of Care Form (MA 1148)/ Prior Authorization Request

Prior Authorizations may be submitted online via Web Portal. Once the provider logs in, the provider will select Prior Authorization, Enter PA request, and select Mental Health. The provider will enter the beneficiary ID number. The Prior Authorization request form will generate as a fillable form.

Section 1: Provider Information

This section must be completed with information about the Medicaid mental health service provider who plans to provide the service(s) for which prior authorization is being sought. Line 1 of this section (Name

of Physician) should contain the name of the service provider and the provider number under which the service will be billed. This information will automatically populate in online PA requests.

Section 2: Medical Data

Lines A, B (if applicable) and C should be completed when requesting day treatment services or psychotherapy services for beneficiaries age 3-20 age three (3) through twenty (20) that exceed the yearly standards. Lines A, B, and C need not be completed for psychotherapy services for a child under age 3 three (3) or for any evaluative service request.

Line D **MUST** contain a statement indicating why the child needs the mental health service(s) in question. Justification for services beyond the standard allotments (daily or **yearly**) may be included here or attached separately if additional space is needed. Documents may be uploaded with online PA requests.

When billing under a group number, the servicing provider's name, title, and provider number must also be entered.

Section 3: Patient Information

The minimum information required includes the following: in this section is:

- Name of Child (This field will automatically populate in online requests.)
- Child's Medicaid ID Number (This field will automatically populate in online requests.)
- Child's Date of Birth (This field will automatically populate in online requests.)
- The Name and **either** phone number (preferable) **or** address (if there is no phone) of the party who is responsible for the child
- The physical location of the child (Hospital, Home, Other—specify "other")

All other information in this section is optional.

Section 4: Services Requested

This section should contain only those services intended to be provided by the servicing provider listed in Section I. For each service for which PA is being requested, one line in this section should contain:

- The abbreviation for the service being requested. Acceptable abbreviations for the mental health services covered in this manual are: Ind/Fam/Gp Therapy, Psych Eval, Dev Eval, Neuropsych, Day Tx).
- The number of service units being requested for the remainder of the fiscal year (July 1-June 30).
- The code for the service. Online requests will auto populate the procedure description field when the code is entered.

Below the last service request, the provider **MUST** identify the date s/he that the provider wishes the service authorization to begin. This line would read "Start date = xx/xx/xx". The provider should submit requests for additional services at least two (2) weeks prior to the expected need.

Sections 5 and 6 are for use by Medicaid.

Section 7: Certification of Medical Necessity

This section must be signed by the provider who will deliver the services (not necessarily a physician or nurse practitioner) for which authorization is being requested. By signing and dating the form, the provider is attesting to the medical necessity of the requested services. **If there is a change of servicing provider within the same provider group (after approval has been given for the service but before the service has been provided), the new provider should countersign the approved PA form and fax a copy of the form to DOM at 604-359-1383 601-576-4163.** For online PA requests, the Certification of Medical Necessity box must be checked in order to successfully submit the PA or PA Addendum.

Instructions for Completing the Prior Authorization Addendum to Plan of Care Form (MA 1148A)

Block in Upper Right Corner

Enter the PA number from the original POC. Enter the original online PA number and submit for online PA Addendum request. The original PA will appear.

Section 1: Provider Information

This must be the same provider who signed the original POC form. Enter the provider's name. Any other information is optional. This field will automatically populate in online PA Addendums.

Section 2: Medical Data

Lines A, B (if applicable) and C should be completed for all psychotherapy services. Lines A, B and C need not be completed for evaluative services. Line D need not be completed, as a statement of justification must be provided in Section 4, Medical Necessity.

Section 3: Patient Information

Complete all information requested: the child's name, Medicaid number and date of birth. These information fields will automatically populate in online PA Addendums.

Section 4: Medical Necessity

Complete a summary statement explaining why additional **services** are needed within the time period already authorized. When additional time is being requested for an evaluation, the provider should state BOTH why the evaluation was delayed beyond the initial three months ("not enough time provided" will not be considered adequate justification) AND the facts which establish that medical necessity still exists. In either case, the provider should include any factors that have a bearing on the request, e.g., events that have caused set-backs or delayed progress. The justification statement may be continued on a separate paper if needed. Documents may be uploaded with online PA Addendum requests.

Section 5: Services Requested

Each line should contain the abbreviation for the service being requested (e.g., Ind/Fam/Gp Therapy), the number of additional service units being requested, and the code for the service. Online PA Addendum requests will automatically generate a procedure code description when code is entered.

Sections 6 and 7 are reserved for Medicaid use.

Section 8: Certification of Medical Necessity

This must be signed by the provider who will deliver the services (not necessarily a physician or nurse practitioner) for which authorization is being requested. By signing and dating the form, the provider is attesting to the medical necessity of the requested services. The Certification of Medical Necessity box must be checked in order to submit a PA Addendum.

Division of Medicaid	New: <input checked="" type="checkbox"/>	Date: 10/01/02
State of Mississippi	Revised: <input checked="" type="checkbox"/>	Date: 04/01/09
Provider Policy Manual	Current:	
Section: Community-Based Mental Health Services	Section: 21.17	
<u>Therapeutic and Evaluative Mental Health</u>	Pages: 1	
<u>Services for Children</u>	Cross Reference:	
Subject: Post Utilization Review		

Providers participating in the Mississippi Medicaid Program are reimbursed for services rendered in compliance with the respective program manual(s) and subsequent program instructions. DOM will periodically identify, through a random selection process, a percentage of Medicaid beneficiaries who have received mental health services within a given period of time and request their treatment records for review. Providers are required by the terms of their Provider Agreement with DOM to comply with the request to produce records. ~~make beneficiaries' records available as requested.~~ Providers who fail to comply with such request in a timely manner could jeopardize their status as active providers.

Providers whose cases are selected for review will be given complete instructions regarding submission of clinical documents at the time of notification.

Division of Medicaid	New:	Date:
State of Mississippi	Revised: X	Date: 03/01/07
Provider Policy Manual	Current:	04/01/09
Section: Community-Based Mental Health Services	Section: 21.18	
Therapeutic and Evaluative Mental Health	Pages: 2	
Services for Children	Cross Reference:	
Subject: Clinical Record Review Process	Therapeutic Services Record Review 21.19	
	Psychological Services Record Review 21.20	

Purpose and Goals

The purpose of a clinical record review is to verify that a provider is in compliance with applicable state and federal requirements for mental health treatment and to monitor the quality of treatment being provided to Medicaid beneficiaries.

The goals of clinical record review include are:

- Assessing to ~~assess~~ the appropriateness and quality of mental health services being provided to Medicaid beneficiaries. ~~and~~
- Giving to ~~give~~ clear, specific feedback regarding review findings to mental health service providers so that services may be enhanced.

Record Selection

Beneficiary records will be selected several times a year for review by DOM, Division of Mental Health Services. Some records will be selected because dates/amount of services billed indicate a pattern of intensive treatment. Other records will be selected randomly.

Provider Notification

Providers whose clients have been identified for record review will be notified by letter. The notification letter will indicate which components of the clinical record should be copied and submitted for review. Records must be submitted by parcel post delivery service (UPS or FedEx) or personally delivered ~~by a specified date, which will be 5-7~~ within five (5) to seven (7) calendar days from the date of the notice.

Record Review

- **Therapeutic Services** (individual, family and group therapy) will be reviewed for compliance with the standards. ~~outlined in Section 21.19, CBMHS Therapeutic Services Record Review. Refer to Provider Policy Manual Section 21.19 for Therapeutic Services Record Review policy.~~
- **Psychological Evaluations** will be reviewed for compliance with the standards. ~~outlined in Section 21.20, CBMHS Psychological Evaluation Record Review. Refer to Provider Policy Manual Section 21.20 for Psychological Evaluation Record Review policy.~~

Provider Feedback

Providers will be notified of the general results of the review within ~~30~~ thirty (30) calendar days after their record submission. Feedback will be given in the form of a status determination letter mailed to each provider. The review outcome will be categorized as:

- **SATISFACTORY**
The provider's name will be removed from the random selection pool for the next review period, insuring that the provider will not be randomly selected to submit any further records for at least twelve (12) months. However, if any of the provider's dates/amount of services billed indicates a pattern of intensive treatment, those records may still be selected for review, regardless of a satisfactory outcome of the previous review.
- **CONTINUED REVIEW**
This is an interim outcome only. Reviewers may require additional records from a particular provider or more information regarding a particular case before determining the results of a review. If this is the case, the provider will be contacted and asked to submit the additional documentation within fourteen (14) 14 calendar days of the request. ~~In this case,~~ The provider will be notified of the final results of the his/her review within thirty (30) 30 calendar days after of the last document submission.
- **IMPROVEMENT NEEDED**
Minor Improvements are needed. The provider's letter will contain information about what improvements are required. His/her name will remain in the selection pool during the subsequent twelve (12) 12 months.

Substantial Improvements are needed. The provider's letter will contain information about what improvements are required. The provider will be pre-selected for further record review in the next review period.
- **UNSATISFACTORY**
The provider will be informed by letter regarding further action.

Appeals Process

If a provider is dissatisfied with the final results of a record review or has a complaint about the review process, the concerns/points of disagreement may be expressed in a written request to appeal. The appeal must be filed with thirty (30) calendar days from the date of the status determination. Requests should be mailed/delivered to: he/she should address his/her concerns in writing within 30 calendar days of the date of his/her status determination to the:

Director, ~~Division of Mental Health Services~~
Bureau of Long Term Care
Division of Medicaid

~~Division of Medicaid~~
Bureau Director, Bureau of Mental Health Programs
Walter Sillers Building
550 High Street, Suite 1000
Jackson, MS 39201

The provider will receive written notification of the decision within thirty (30) days

~~If the provider is dissatisfied with the results of this appeal, her/she should request an administrative hearing in writing within 30 calendar days to the:~~

Executive Director
Division of Medicaid

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Date: Date: 3/1/07 04/01/09
Section: <u>Community-Based Mental Health Services Therapeutic and Evaluative Mental Health Services for Children</u>	Section: 21.19 Pages: 3 Cross Reference: Consent to Bill Medicaid 21.09	
Subject: Therapeutic Services Record Review		
Provider _____ # _____	Beneficiary _____ # _____	
Reviewer _____	Date _____	

Records of Therapeutic Services (Therapy and Case Management) will be reviewed for compliance with the standards outlined below. Some of the items are rated on a simple "Yes(Y)/No(N)" basis. Other items are rated on the basis of "Satisfactory(S)/Improvement Needed (I)/Unsatisfactory(U)," depending upon either the *frequency* or *quality* of compliance documented by the record.

ITEM	ADMINISTRATIVE	RATING
1	Records were submitted in timely manner	Y N
2	Records were organized, could be easily reviewed	Y N
3	Consent for treatment properly executed	Y N
4	Consent to bill Medicaid properly executed	Y N
5	Session notes match billing data	S I U
	MEDICAL NECESSITY	
6	Clinical record (intake info, treatment plan and/or notes) indicate that some type of mental health services are medically necessary ____ child has significant stressors, needs support ____ child is at risk for more restrictive interventions if treatment is not provided now ____ strengthening coping/social skills now is proactive towards preventing future deterioration ____ a treatment need has been identified by the child/family	Y N
7	Treatment method/techniques used are appropriate to stated problems, in accordance with good practice standards	Y N
8	The amount/frequency of treatment is appropriate/medically necessary, given the nature/severity of the child's problems	Y N
	SERVICES	
	Bio-Psycho-Social Assessment	
9	Identifies presenting problem/problem history	S I U
10	Documents family background	S I U
11	Documents medical history	S I U
12	Documents educational information	S I U
13	Documents history of previous mental health treatment	S I U
14	Contains clinician's assessment/recommendations	S I U
	Treatment Planning	
15	Plan was developed by date of third therapy session	Y N
16	Plan contains a multi-axial diagnosis	Y N
17	Plan identifies the child's and/or family's strengths	S I U
18	Plan identifies clinical problems on which treatment will focus	S I U
19	Plan states treatment goals for each problem	S I U
20	Treatment objectives are given for each goal	S I U
21	Objectives have target dates for achievement	S I U
22	Treatment modalities and/or strategies are identified for each objective	S I U

23	Plan is signed/dated by provider AND client and/or client's family member	Y N
24	Plan is updated/revised every 3 months	Y N N/A
	Service Notes	
25	Include the date of service	S I U
26	Include the time of day the service was provided <u>by indicating time in and time out</u>	S I U
27	Identify the type of service provided	S I U
28	Include the length of time spent delivering the service	S I U
29	State who received or participated in the service	S I U
30	Relate to the treatment plan	S I U
31	Give a summary of what transpired in the session	S I U
32	Authenticated by signature/initials of service provider	S I U
	Beneficiary/Family Member Interview	N/A
33	Child/family can identify the problem for which services were sought	S I U
34	Child/family understand what goals of treatment are/were	S I U
35	Child/family understand/agree with strategies employed in treatment	S I U
36	Child/family understand/agree with frequency of treatment sessions	S I U
37	Child/family understand/agree with duration of therapy	S I U
38	Family are/were included in treatment, given guidance or recommendations to help child	S I U
39	Child/family understand/agree with criteria for termination of therapy	S I U
40	Child/family members have a positive perception of therapist, feel progress is being/was made and can explain why	S I U
41	Child/family members feel they were treated with respect	S I U
	Therapist Interview	N/A
42	Therapist is able to articulate his/her philosophy of treatment	S I U
43	Therapist can identify the problem for which services were sought in this case	S I U
44	Therapist can explain his/her treatment strategy in this case	S I U
45	Therapist can explain/justify the frequency of treatment sessions	S I U
46	Therapist can explain/justify the duration of treatment	S I U
47	Therapist can relate guidance/recommendations given child's family	S I U
48	Therapist can explain/justify criteria for termination of treatment	S I U
49	Therapist worked cooperatively with interviewer(s) regarding this case	S I U

A brief explanation of the rating system follows. **Therapeutic Record Review Rating System**
Instructions/Explanation

1-3. Self-explanatory.

4. Consent to bill Medicaid properly executed – A sample "consent to bill Medicaid" form is provided in ~~Section 21.09.~~ Refer to Provider Policy Manual Section 21.09 for Consent to Bill Medicaid policy and a sample of the form.

5. Session notes match billing data – If any discrepancy is found between billing and documentation of sessions (i.e. no documentation is found for a session for which Medicaid was billed), additional beneficiary records will be requested for review to determine whether the discrepancy was merely an oversight or a pattern of inadequate documentation exists. If a pattern is found, the provider will be referred to Program Integrity for investigation.

6. Clinical record (intake info, treatment plan and/or notes) indicates that some types of mental health services are medically necessary – The list of justifications for medical necessity given here is representative but not exhaustive.

7. Treatment method/techniques used are appropriate to stated problems, in accordance with good practice standards – Even if the child's need for *some* form of mental health treatment is clear, the type of treatment being provided must be appropriate to the nature/severity of the child's problems in order to pass the "medical necessity" test.

8. The amount/frequency of treatment is appropriate/medically necessary, given the nature/severity of the child's problems – The length and frequency of treatment sessions, as well as the duration of the treatment process over time, must be consistent with the nature/severity of the child's problems. At a minimum, the provider will be required to repay any monies disbursed for services which are judged to be in excess of medical necessity

9-14. The bio-psycho-social assessment is the basic "intake assessment" which a clinician does at the outset of treatment. It must include, at a minimum, the information identified here including any psychological evaluations that have been administered.

15. ~~The treatment plan~~ should be completed and signed by the clinician and the child and/or family member by the date of the third therapy session.

~~16-22. Self-explanatory.~~

15-22. Self explanatory.

23. The treatment plan should be completed and signed by the clinician and the child and/or family member by the date of the third therapy session.

24-32. Self-explanatory.

33-49. Beneficiary/family and/or therapist interviews will not be conducted as a part of every review. When they are included, these are the items on which those portions of the review will be rated.

Division of Medicaid	New:	Date:
State of Mississippi	Revised: X	Date: 03/01/07
Provider Policy Manual	Current:	04/01/09
Section: Community-Based Mental Health Services	Section: 21.20	
Therapeutic and Evaluative Mental Health	Pages: 4	
Services for Children	Cross Reference: Consent to Bill	
	Medicaid 21.09	
Subject: Psychological Evaluation Record Review		
Provider _____ # _____	Beneficiary _____ # _____	
Reviewer _____	Date _____	

Records of Psychological Evaluations will be reviewed for compliance with the standards outlined below. Some of the items are rated on a simple "Yes(Y)/ No(N)" basis. Other items are rated on the basis of "Satisfactory(S)/Improvement Needed (I) / Unsatisfactory(U)," depending upon the quality of compliance documented by the record.

ITEM	ADMINISTRATIVE	RATING
1	Records were submitted in a timely manner	Y N
2	Records were organized, could be easily reviewed	Y N
3	Consent for treatment properly executed	Y N
4	Consent to bill Medicaid properly executed	Y N
5	Billing data match information in the clinical record	Y N
	MEDICAL NECESSITY	
6	Medical necessity for this evaluation is documented or clearly evident ___ there is a history of unexplained treatment failures ___ there are questions that an eval might help to answer (the "referral question") ___ uncertainties about diagnosis and/or treatment ___ unexplained learning problems when child doesn't qualify for SpEd evaluation ___ need to assess child's potential for success in a particular type of program ___ child was placed in DHS custody WITHIN 90 DAYS prior to the assessment date ___ eval required by DOM for admission to a PRTF	Y N
	SERVICES	
7	Pre-eval background/information gathering session is documented	Y N
8	Report giving results of the evaluation is in clinical file	Y N
9	Report is completed within 30 days of completion of the assessment	Y N
10	Evaluative tools (tests, rating instruments, etc.) utilized were appropriate to referral question, the unique characteristics of the child, and the testing situation	S I U
11	Report is a synthesis of information gleaned from testing, observation, interviews with child/family, collateral contacts	S I U
12	Report adequately addresses the referral question	S I U
13	Report reflects an understanding of the child's/family's strengths	S I U
14	Report contains practical recommendations for those working with the child	S I U
15	Report is signed by psychologist who conducted the evaluation	Y N
16	Post-eval feedback to family (and child, if appropriate) is documented	Y N
17	Post-eval feedback to referral source is documented	Y N N/A
18	Post-eval feedback to family/child and/or referral source includes information about how to implement the psychologist's recommendations	S I U
19	Date, time in, time out, and amount of time spent assessing the child (interviews, testing, etc.) is documented in the clinical record	Y N
20	Date and amount of time spent preparing the report is documented in the clinical record	Y N

A brief explanation of the rating system follows. **Psychological Evaluation Review Rating System Instructions/Explanation**

1-3. Self-explanatory.

- 4. Consent to bill Medicaid properly executed** – A sample: “consent to bill Medicaid” form is provided in Section 21.09. Refer to Provider Policy Manual Section 21.09 for Consent to Bill Medicaid policy and a sample of the form.
- 5. Billing data match information in the clinical record** – If any discrepancy is found between billing and documentation of services is found, the provider may be asked to submit additional records for review. If a pattern of inadequate or improper documentation is found, the provider will be referred to Program Integrity for investigation.
- 6. Medical necessity is documented or clearly evident** – There should be clear evidence either by history or by documented observation that a psychological evaluation is necessary to answer the referral question.

The following are indicators of medical necessity (this list is representative, but not exhaustive):

- **There is a history of unexplained treatment failures** – child has participated in a number of types of treatment with limited success.
- **There are questions that an evaluation might help to answer, AND AN EVALUATION IS THE MOST APPROPRIATE WAY TO ADDRESS THE REFERRAL QUESTION.** In order to determine this, the referral question must first be very clearly defined (e.g., “to determine if psychotic symptoms are interfering with functioning” versus “doesn’t get along”). If it is then apparent that the referral question can be answered through less intrusive and time consuming means (e.g., diagnostic interview, behavioral interventions, referral to physician if medication was stopped by family and symptoms re-emerged), these interventions should be made and testing should not be pursued.

Examples of referral questions that would likely indicate that testing is warranted include (this list is representative, but not exhaustive):

- **Uncertainties about diagnosis and/or treatment** – child is exhibiting significant symptoms (e.g., depression, psychosis, severe acting out) of unclear etiology and an evaluation of those symptoms would aid in treatment planning. In general, symptoms of ADHD, in and of themselves, are not considered sufficient basis for a psychological evaluation, unless it is clearly evident that less intrusive interventions such as behavioral approaches and parent education have been attempted and were not successful.
- **Unexplained learning problems when a child does not qualify for Special Education (SpEd) evaluation** – learning style or difficulties are interfering with school performance or psycho-social functioning in non-educational settings. Children who appear to be eligible for SpEd services should be referred to the school system for evaluation.
- **Need to assess child’s potential for success in a particular type of program** – an assessment of child’s intellectual and/or psychological functioning would be helpful in determining if he/she would benefit from a particular program.

-
-
- **Child was placed in Mississippi Department of Human Services (DHS) DHS custody WITHIN NINETY (90) 90 DAYS prior to the assessment date – self explanatory. Routine assessments of children in custody for longer than ninety (90) 90 days will not be reimbursed unless medical necessity is clearly evident and documented.**
 - **Evaluation required by the Division of Medicaid for admission to a psychiatric residential treatment facility –self explanatory**
- 7. Pre-eval background/information gathering session is documented** – This session should be conducted separate and apart from the evaluation, unless to do so would pose a hardship for the family and/or child. Medical necessity for the evaluation should be determined in this session, and a summary of the session should be documented either in case notes or in the evaluation report. This session should also serve as a means to stop duplication of services by gathering information on psychological evaluations previously administered.
- 8-9. Self explanatory.**
- 10. Evaluative tools utilized were appropriate to the referral question, the unique characteristics of the child, and the testing situation** – Instruments should clearly address the referral question, and be psychometrically sound (recognized as having good reliability and validity). It should also be clear that the examiner has considered the unique characteristics of the child (e.g., how verbal the child is, the child's primary language, etc.) and the demands of the testing situation (e.g. a child being tested in an office primarily staffed by people of different ethnicity and possibly feeling intimidated, a child being tested within days of being taken into custody, a child being tested at a group home and possibly distracted by noise, etc.) both in choosing instruments and interpreting results. ***Examiners are cautioned to avoid administering the same battery of instruments to all referrals without giving significant consideration to the factors discussed in this section.***
- 11. Report is a synthesis of information gleaned from testing, observation, interviews with child/family, collateral contacts** – The report should not be merely a recitation of data and facts. Rather, it should pull together information from all sources and generate logical and helpful conclusions from that information. It should be evident that attempts were made to gather information from all relevant sources (e.g. if the referral question relates to school, contact should be made with relevant school personnel). Computer-generated reports or recommendations are not considered an adequate synthesis of information.
- 12. Report adequately addresses the referral question** – Each step of the testing process (information gathering, test selection, test administration, interpretation, recommendations and feedback) should relate back to the referral question. For example, if the referral question relates to depression, and the report focuses primarily on intellectual and achievement testing, it is highly unlikely that the referral question has been adequately addressed. When a test can be given for a variety of reasons (e.g., an I.Q. test), the report should clearly explain the purpose of the test for this particular evaluation. Examiners are cautioned against using generic lists of recommendations.
- Recommendations should be specifically tailored to the referral question and the unique characteristics of the child and family.
- 13. Report reflects an understanding of the child's/family's strengths** – The report should not only address needs of the child and family, but also recognize strengths. Strengths should serve as a guide in synthesizing information and formulating recommendations. Strengths include

characteristics (e.g., artistic ability), as well as cultural and/or family values (e.g., strong religious individual identification) and available resources (e.g., extended family support).

- 14. Report contains practical recommendations for those working with the child –** Recommendations should relate to the referral question, be practical, and reflect an understanding of the child's/family's values, resources and possible limitations.

- 15. Self explanatory.**

- 16-17. Post eval feedback to family (and child, if appropriate) and referral source is documented –** Case records should indicate that this feedback occurred, and provide a summary of it.

- 18. Post eval feedback to family/child and/or referral source includes information about how to implement the psychologist's recommendations –** Documentation of these sessions should reflect that the psychologist insured that the family/child and/or referral source understood the recommendations and were assisted in developing a plan to implement them. For example, if the psychologist recommends a helpful book to parents, the psychologist should insure that the book is on the parent's reading level and that they have the resources to obtain it. Similarly, if a specific type of therapy or activity (e.g., after school program) is recommended, the psychologist should provide contact information for those resources and be sensitive to any financial constraints the family might have in pursuing those options.

- 19-20. Progress notes, test reports and billing records should accurately reflect when all phases of testing, scoring and report writing were completed.**